



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/06/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Acromioplasty with a Mumford resection of the left shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR  
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Orthopedic Surgery

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Acromioplasty with a Mumford resection of the left shoulder - Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An MRI of the cervical spine interpreted by M.D. dated 12/06/06  
Evaluations with Dr. (no credentials were listed) dated 04/18/07, 05/14/07,  
06/25/07, and 08/20/07

X-rays of the left shoulder interpreted by M.D. dated 04/18/07  
An MRI of the left shoulder interpreted by M.D. dated 05/08/07  
Evaluations with an unknown physician (the signature was illegible) at Medical Clinics dated 07/13/07, 07/26/07, 08/15/07, 09/05/07, 10/02/07, 10/29/07, 11/21/07, and 12/14/07  
An authorization for release of medical records form dated 01/14/08  
Evaluations with M.D. dated 01/22/08, 01/30/08, and 02/04/08  
X-rays of the left shoulder interpreted by Dr. dated 01/22/08  
A prescription from Dr. dated 01/22/08  
An MRI of the left shoulder interpreted by M.D. dated 01/30/08  
A letter of non-authorization, according to the ODG, from M.D. dated 02/01/08  
Letters of non-authorization, according to the ODG, from Utilization Review Nurse dated 02/05/08 and 02/28/08  
A letter from Attorney at Law P.L.L.C., dated 02/13/08  
A letter from Dr. dated 02/18/08  
A peer review report and letter of non-authorization, according to the ODG, from M.D. dated 02/26/08  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

An MRI of the cervical spine interpreted by Dr. on 12/06/06 was essentially unremarkable. On 04/18/07, Dr. recommended an MRI, Lortab, and Mobic. X-rays of the left shoulder interpreted by Dr. on 04/18/07 were normal. An MRI of the left shoulder interpreted by Dr. on 05/08/07 revealed AC joint arthritis and a linear tear of the posterior glenoid labrum. On 05/14/07, Dr. recommended physical therapy. On 07/13/07, the unknown physician from Medical Clinics recommended Vicodin. On 08/15/07, the same physician recommended a neurology evaluation and Cymbalta. On 10/29/07, the unknown physician referred the patient to an orthopedist. On 11/21/07, the unknown physician prescribed Ultram. X-rays of the left shoulder interpreted by Dr. on 01/22/08 revealed a type II acromial configuration. An MRI of the left shoulder interpreted by Dr. on 01/30/08 revealed moderate degenerative disease of the AC joint. On 01/30/08, Dr. recommended left shoulder surgery. On 02/01/08, Dr. wrote a letter of non-authorization for the surgery. On 02/05/08 and 02/28/08, wrote letters of non-authorization for an acromioplasty. On 02/18/08, Dr. wrote a letter requesting the shoulder surgery. On 02/26/08, Dr. wrote a letter of non-authorization for surgery.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

This patient has had a history of pain in the shoulder that has been recalcitrant to conservative treatment. Objective testing revealed abnormalities in the AC joints and an acromion that is down turning. The patient has had pain in the left

shoulder that has been unrelenting despite normal conservative treatment including injections and physical therapy. The patient said this problem has been ongoing since 2006. I think the patient has exhausted all conservative measures and I believe this patient is a candidate for surgery, according to the ODG. The patient has undergone an appropriate amount of conservative treatment and had the necessary steps prior to undergoing surgery. Therefore, the requested acromioplasty with a Mumford resection of the left shoulder is reasonable and necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE  
(PROVIDE A DESCRIPTION)**
  
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**